105 W 8th Ave
Suite 7010
Spokane, WA
99204
509-747-6194 Ph.
509-838-0824 Fax

9922 N Nevada
Spokane, WA
99218
509-489-1081 Ph.
509-483-0338 Fax

13414 E Mission
Spokane, WA
99216
509-747-6194 Ph.
509-838-0824 Fax

Authorization To Release Health Care Information

Patient's Name: ______________________________ Date of Birth: ___________
SS Number: _________________________ Previous Name: ________________

I request and authorize ______________________________ to release health care information of the patient named above to:

Please release patient information to the following listed entities:
Name: ____
Address: ____
City, State and Zip Code: ____

This request and authorization applies to:
(Please check all that applies)

______ All Health Care Information

______ Health care information relating to the following medical condition, or date of treatment ____

______ Other ____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health and drug or alcohol use.

If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health and drug or alcohol use, Surgical Specialists of Spokane is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I may revoke this authorization in writing at any time, except to the extent that action has been taken based upon it. Even if I do not revoke it, this authorization expires *90 days* from the date signed.

____ ______________________
Signature of Patient or Patient's authorized Agent Date

____
Relationship of agent signing on behalf of the patient (Parent, Legal Guardian, etc.)